Complete Summary

GUIDELINE TITLE

Uterine cancer.

BIBLIOGRAPHIC SOURCE(S)

Uterine cancer. Philadelphia (PA): Intracorp; 2005. Various p. [13 references]

GUIDELINE STATUS

This is the current release of the guideline.

All Intracorp guidelines are reviewed annually and updated as necessary, but no less frequently than every 2 years. This guideline is effective from April 1, 2005 to April 1, 2007.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Uterine cancer:

- Endometrioid adenocarcinoma
- Uterine sarcoma
  - Carcinosarcoma (mixed malignant mullerian tumors [MMMT]
  - Leiomyosarcoma (LMS)
- Endometrial stromal sarcoma
- Unclassified
  - Rhabdomyosarcoma
  - Angiosarcoma
  - Fibrosarcoma
  - Chondrosarcoma

- Liposarcoma

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Oncology
Radiation Oncology
Surgery

INTENDED USERS

Allied Health Personnel
Health Care Providers
Health Plans
Hospitals
Managed Care Organizations
Utilization Management

GUIDELINE OBJECTIVE(S)

To present recommendations for the diagnosis, treatment, and management of uterine cancer that will assist medical management leaders to make appropriate benefit coverage determinations

TARGET POPULATION

Women with uterine cancer

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation/Screening/Risk Assessment

1. Physical examination and assessment of signs and symptoms and risk factors
2. Diagnostic tests:
    - Endometrial aspiration or biopsy
    - Dilation and curettage (D&C)
    - Chest x-ray (CXR)
    - Transvaginal ultrasound (US)
    - Bone scan
    - Abdominal computed tomography (CT) scan
    - Hysteroscopy
    - Blood work (complete blood count [CBC], Ca 125 tumor marker

3. Prophylactic screening schedule recommended by American Cancer Society

Management/Treatment

1. Total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH-BSO)
2. Radiation therapy (RT)
3. Palliative TAH-BSO with chemotherapy and/or hormonal therapy
4. Physical therapy if indicated
5. Referral to specialists
6. Case management strategies, including case initiation, case management focus, and discharge

MAJOR OUTCOMES CONSIDERED

- Risk factors for uterine cancer
- Five-year survival rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Searches were performed of the following resources: reviews by independent medical technology assessment vendors (such as the Cochrane Library, HAYES); PubMed; MD Consult; the Centers for Disease Control and Prevention (CDC); the U.S. Food and Drug Administration (FDA); professional society position statements and recommended guidelines; peer reviewed medical and technology publications and journals; medical journals by specialty; National Library of Medicine; Agency for Healthcare Research and Quality; Centers for Medicare and Medicaid Services; and Federal and State Jurisdictional mandates.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Not Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not stated

METHODS USED TO ANALYZE THE EVIDENCE

Review
Review of Published Meta-Analyses

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

A draft Clinical Resource Tool (CRT or guideline) is prepared by a primary researcher and presented to the Medical Technology Assessment Committee or the Intracorp Guideline Quality Committee, dependent upon guideline product type.

The Medical Technology Assessment Committee is the governing body for the assessment of emerging and evolving technology. This Committee is comprised of a Medical Technology Assessment Medical Director, the Benefit and Coverage Medical Director, CIGNA Pharmacy, physicians from across the enterprise, the Clinical Resource Unit staff, Legal Department, Operations, and Quality. The Intracorp Guideline Quality Committee is similarly staffed by Senior and Associate Disability Medical Directors.

Revisions are suggested and considered. A vote is taken for acceptance or denial of the CRT.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Diagnostic Confirmation

Subjective Findings

- Abnormal vaginal bleeding, occurs in 90% of cases
- Postmenopausal bleeding (most frequent sign)
- Irregular bleeding or heavy menses in premenopausal women
- Pelvic pain
- Unintentional weight loss

Objective Findings

- Presence of risk factors (see Description section in the original guideline document)
- On pelvic examination
    - Vagina - usually normal
    - Cervix - deformed or excessively firm (indicative of possible metastasis)
    - Uterus - normal or grossly enlarged size
- Lymphadenopathy, ascites, hepatosplenomegaly, and intra-abdominal masses, if metastatic disease at presentation (uncommon)

Diagnostic Tests

- Endometrial aspiration or biopsy
    - Endometrial biopsy is considered diagnostic for ruling out pre-cancerous hyperplasia and precedes lymph node biopsy
- Dilation and curettage (D&C)
    - If endometrial biopsy fails to produce an adequate tissue sample, or
    - Biopsy findings are suggestive, not conclusive, of cancer diagnosis
- Pap (Papanicolaou) test, routine for cervical cancer screening, is rarely effective in detecting endometrial (uterine) cancer
- American Cancer Society (ACS) recommends the following screening schedule:
    - Women age 40 or older - annual pelvic examination by a health professional
    - Symptomatic women at menopause - endometrial biopsy
    - Asymptomatic women at very high risk of developing endometrial cancer - endometrial biopsy at menopause and periodically thereafter at the discretion of the physician
- Chest x-ray (CXR)
    - CXR is performed to determine the extent of metastasis or cardiopulmonary comorbidities.
- Transvaginal ultrasound (US)
    - US measures the thickness of the endometrium for staging purposes.
- Bone scan

        - Performed when bone pain is present; identifies sites of bony metastasis
- Abdominal computed tomography (CT) scan
    - Abdominal CT is performed to establish extra-uterine metastasis and for staging purposes.
- Hysteroscopy
    - Direct visualization of the uterine cavity with fiber optic technique
        - May be helpful in persistent uterine bleeding after D&C that is negative for cancer
- Blood work
    - Complete blood count (CBC) to evaluate for anemia
    - CA 125 tumor marker: secreted by some, not all, endometrial cancer cells
        - Very elevated serum CA 125 suggestive of extra-uterine spread of cancer

Differential Diagnosis

- Atrophic endometritis or vaginitis
- Endometrial hyperplasia
- Endometrial or cervical polyps
- Nonmalignant side effects of exogenous estrogen use
- Cervical cancer (see the Intracorp guideline for Cervical Cancer)
- Trauma
- Cervicitis or pelvic inflammatory disease (PID) (see the Intracorp guideline for Pelvic Inflammatory disease)

Treatment Options

- Surgical: Total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH-BSO), selective para-aortic lymph nodes at time of surgery and peritoneal cytologic examination for those patients who can tolerate surgery
    - Care Setting: acute inpatient
- Radiation therapy (RT)
    - External and intrauterine RT with cesium or intrauterine therapy alone
    - Presurgical RT: For Stage II disease with grossly distorted cervix
    - Postoperative RT
    - Radiation Care Setting: clinic or free-standing outpatient; unless severely ill/deconditioning indicates acute inpatient, subacute/skilled nursing facility inpatient, or hospice inpatient
- Palliative TAH-BSO, with chemotherapy and/or hormonal therapy
    - For Stage III and IV disease, treatment is tailored to the individual.
    - TAH-BSO, for palliation of bleeding
    - Chemotherapy and hormonal, for selected patients (see the Intracorp guideline Chemotherapy)
    - TAH-BSO Primary Care Setting: acute inpatient
    - Chemotherapy maintenance setting: Primary-clinic or free-standing outpatient, physician's office, or home care; unless severely ill/deconditioning indicates acute inpatient, subacute/skilled nursing facility inpatient, or hospice inpatient
    - Hormone Therapy Care Setting: self-administered

Duration of Medical Treatment

- Medical - Optimal: 3 day(s), Maximal: 42 day(s)
    - Varies, depending on extent of disease and necessary interventions

Additional information regarding primary care visit schedules, referral options, specialty care, and physical therapy is provided in the original guideline document.

The original guideline document also provides a list of red flags that may affect disability duration, and return to work goals, including

- Endometrial biopsy, diagnostic hysteroscopy
- After hospitalization for TAH-BSO without complications
- After radiation therapy

Note: Some patients with this condition may never return to work.

Case Management Directives (refer to the original guideline for detailed recommendations)

Case Initiation

Establish Case

- Document baseline information, history, key physical findings, patient's understanding, and safety factors.
- See Chemotherapy Chart in the original guideline document.
- The American Joint Committee on Cancer encourages use of the "TNM" classification system (T=primary tumor size; N=lymph node involvement; M=metastasis).
- Provide contact information for local and national support groups.

Coordinate Care

- Advocate for patient by managing utilization and charges.
- Document treatment plan.

Case Management Focus

Activity Deficit

- Instruct regarding post-cone biopsy plan for resumption of activities (work, recreational, and sports), bathing, and sexual intercourse.
- Document activity alteration as none, mild, moderate, severe, dependent, or bed-bound (based on most recent performance status) and interventions required.

Chemotherapy Intolerance

- Assess status, acute versus chronic, of toxic side effects on rapidly growing tissues, including bone marrow, epithelium, hair, sperm, and document intervention recommended.

Hemodynamic Instability

- Document bleeding complications, severity, and intervention recommended.

Immune Compromised

- Document establishment of protective isolation measures for a white blood cells count (WBC) less than 1,000/mm^3, implying dangerous susceptibly to infection.

Inadequate Nutrition

- Use optimal goal of remaining within 10% of pretreatment weight to document hydration and nutrition deficit as mild, moderate, severe and response needed.

Mental and Emotional Alteration

- Ensure accurate diagnosis of any change in mental status.
- Document baseline or optimal mental and emotional functioning and their alterations due to cancer presence, comorbidity, surgery, or treatments.
- Assess and respond appropriately to the degree of debility caused by alterations listed in the original guideline through benefit coordination or community resource activation.

Pain Control

- Document optimal pain management by characterizing severity and interventions undertaken to remedy or manage pain

Oncologic Emergencies

- Direct the patient to immediately report any excessive vaginal bleeding to attending physician or to activate emergency medical technician (EMT) system.
- Assess post-operatively for and document presence of symptoms of bladder dysfunction, deep vein thrombosis, and pulmonary embolus.
- Document presence of or developing oncologic emergencies and report to attending physician, surgeon, or activate EMT system as necessary.

Radiation Intolerance

- Document whether radiation therapy will be delivered by external beam or by internal radiation source implantation (brachytherapy) and instruct the patient and caregiver accordingly.
- Document presence and severity of radiation side effects.
- Initiate early interventions for complications of radiation therapy.

Respiratory Instability

- Document respiratory deficit as mild, moderate, severe, and dependent, and respiratory rehabilitation enhancement measures.

Skin Integrity Deficit

- Evaluate frequency and need for nursing interventions regarding dressing changes and teaching according to extent of surgery (size of abdominal wound), presence of drains, and rate of wound healing. (See the Intracorp guidelines Hysterectomy and Bowel Surgery: Resection, Colectomy, Colostomy, Ileostomy.)
- Assess and document barriers to rehabilitation involving colostomy or ileostomy.
- Teach the patient about differences in colostomy feces care and cleansing techniques according to colostomy placement: fluid feces, colostomy in ascending colon; mushy, transverse colon; semi-mushy, descending colon; solid, sigmoid.
- Evaluate and document need for enterostomal therapist (ET) instruction in clinic or in home setting.
- Document severity of skin integrity disruption.

Terminal Care

- Document optimal comfort measures and palliative care initiatives.

Discharge

Discharge from Case Management (CM)

- Document return to independence or stabilized functional status and closing conversations with patient, caregiver, physician, pharmacist, and care providers.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis, treatment, and management of uterine cancer that assist medical management leaders to make appropriate benefit coverage determinations

POTENTIAL HARMS

Refer to the Case Management Focus section of the "Major Recommendations" field for information on potential complications and strategies to address them, or refer to the original guideline document.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Uterine cancer. Philadelphia (PA): Intracorp; 2005. Various p. [13 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 (revised 2005)

GUIDELINE DEVELOPER(S)

Intracorp - Public For Profit Organization

SOURCE(S) OF FUNDING

Intracorp

GUIDELINE COMMITTEE

CIGNA Clinical Resources Unit (CRU)
Intracorp Disability Clinical Advisory Team (DCAT)
Medical Technology Assessment Committee (MTAC)
Intracorp Guideline Quality Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

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AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Policies and procedures. Medical Technology Assessment Committee Review Process. Philadelphia (PA): Intracorp; 2004. 4 p.
- Online guideline user trial. Register for Claims Toolbox access at www.intracorp.com.

Licensing information and pricing: Available from Intracorp, 1601 Chestnut Street, TL-09C, Philadelphia, PA 19192; e-mail: lbowman@mail.intracorp.com.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on May 27, 2005. The information was verified by the guideline developer on June 7, 2005.

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